

§ 425.504

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individual quality performance standard measures into four domains:

- (i) Patient/care giver experience.
- (ii) Care coordination/Patient safety.
- (iii) Preventative health.
- (iv) At-risk population.

(2) To satisfy quality performance requirements for a domain:

(i) The ACO must report all measures within a domain.

(ii) ACOs must score above the minimum attainment level for at least one measure in each of the four domains. If an ACO fails to achieve the minimum attainment level on at least 70 percent of the measures in a domain, CMS will take the actions describe in § 425.216(c).

(iii)(A) If the ACO achieves the minimum attainment level for at least one measure in each of the four domains, and also satisfies the requirements for realizing shared savings under subpart G of this part, the ACO may receive the proportion of those shared savings for which it qualifies.

(B) If an ACO fails to achieve the minimum attainment level on all measures in a domain, it will not be eligible to share in any savings generated.

(e) *Methodology for calculating the ACO's overall performance score.* (1) CMS scores individual measures and determines the corresponding number of points that may be earned based on the ACO's performance.

(2) CMS adds the points earned for the individual measures within the domain and divides by the total points available for the domain to determine the domain score.

(3) Domains are weighted equally and scores averaged to determine the ACO's overall performance score and sharing rate.

§ 425.504 Incorporating reporting requirements related to the Physician Quality Reporting System.

(a) *Physician quality reporting system.*

(1) ACOs, on behalf of their ACO provider/suppliers who are eligible professionals, must submit the measures determined under § 425.500 using the GPRO web interface established by CMS, to qualify on behalf of their eligible professionals for the Physician

Quality Reporting System incentive under the Shared Savings Program.

(2)(i) ACO providers/suppliers that are eligible professionals within an ACO may only participate under their ACO participant TIN as a group practice under the Physician Quality Reporting System Group Practice Reporting Option of the Shared Savings Program for purposes of receiving an incentive payment under the Physician Quality Reporting System.

(ii) Under the Shared Savings Program, an ACO, on behalf of its ACO providers/suppliers who are eligible professionals, must satisfactorily report the measures determined under Subpart F of this part during the reporting period according to the method of submission established by CMS under the Shared Savings Program in order to receive a Physician Quality Reporting System incentive under the Shared Savings Program.

(3) If ACO providers/suppliers who are eligible professionals within an ACO qualify for a Physician Quality Reporting System incentive payment, each ACO participant TIN, on behalf of its ACO supplier/provider participants who are eligible professionals, will receive an incentive, for those years an incentive is available, based on the allowed charges under the Physician Fee Schedule for that TIN.

(4) ACO participant TINs and individual ACO providers/suppliers who are eligible professionals cannot earn a Physician Quality Reporting System incentive outside of the Medicare Shared Savings Program.

(5) The Physician Quality Reporting System incentive under the Medicare Shared Savings Program is equal to 0.5 percent of the Secretary's estimate of the ACO's eligible professionals' total Medicare Part B Physician Fee Schedule allowed charges for covered professional services furnished during the calendar year reporting period from January 1 through December 31, for years 2012 through 2014.

(b) [Reserved]

§ 425.506 Electronic health records technology.

(a) ACOs, ACO participants, and ACO providers/suppliers are encouraged to develop a robust EHR infrastructure.

(b) As part of the quality performance score, the quality measure regarding EHR adoption will be measured based on a sliding scale.

(c) Performance on this measure will be weighted twice that of any other measure for scoring purposes and for determining compliance with quality performance requirements for domains.

Subpart G—Shared Savings and Losses

§ 425.600 Selection of risk model.

(a) For its initial agreement period, an ACO may elect to operate under one of the following tracks:

(1) *Track 1.* Under Track 1, the ACO operates under the one-sided model (as described under § 425.604 of this part) for the agreement period.

(2) *Track 2.* Under Track 2, the ACO operates under the two-sided model (as described under § 425.606), sharing both savings and losses with the Medicare program for the agreement period.

(b) For subsequent agreement periods, an ACO may not operate under the one-sided model.

(c) An ACO experiencing a net loss during the initial agreement period may reapply to participate under the conditions in § 425.202(a), except the ACO must also identify in its application the cause(s) for the net loss and specify what safeguards are in place to enable the ACO to potentially achieve savings in its next agreement period.

§ 425.602 Establishing the benchmark.

(a) *Computing per capita Medicare Part A and Part B benchmark expenditures.* In computing an ACO's fixed historical benchmark that is adjusted for historical growth and beneficiary characteristics, including health status, CMS determines the per capita Parts A and B fee-for-service expenditures for beneficiaries that would have been assigned to the ACO in any of the 3 most recent years prior to the agreement period using the ACO participants' TINs identified at the start of the agreement period. CMS does all of the following:

(1) Calculates the payment amounts included in Parts A and B fee-for-service claims using a 3-month claims run out with a completion factor.

(i) This calculation excludes indirect medical education (IME) and disproportionate share hospital (DSH) payments.

(ii) This calculation considers individually beneficiary identifiable payments made under a demonstration, pilot or time limited program.

(2) Makes separate expenditure calculations for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(3) Adjusts expenditures for changes in severity and case mix using prospective HCC risk scores.

(4) Truncates an assigned beneficiary's total annual Parts A and B fee-for-service per capita expenditures at the 99th percentile of national Medicare fee-for-service expenditures as determined for each benchmark year in order to minimize variation from catastrophically large claims.

(5)(i) Using CMS Office of the Actuary national Medicare expenditure data for each of the years making up the historical benchmark, determines national growth rates and trends expenditures for each benchmark year (BY1 and BY2) to the third benchmark year (BY3) dollars.

(ii) To trend forward the benchmark, CMS makes separate calculations for expenditure categories for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(6) Restates BY1 and BY2 trended and risk adjusted expenditures in BY3 proportions of ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(7) Weights each year of the benchmark using the following percentages:

(i) BY3 at 60 percent.

(ii) BY2 at 30 percent.

(iii) BY1 at 10 percent.

(8) The ACO's benchmark may be adjusted for the addition and removal of ACO participants or ACO providers/suppliers during the term of the agreement period.